Washington State Health Care Authority
Public Employees Benefits Board

Medicare+Choice Plan Election Form

Please fill in all information requested. Be sure to read the back of this form.

C

Retiree/Spouse Information

Social Security Number	Last Name (as appears on Medicare card) First Name Middle Initial	Home Phone
Permanent Residential Address	☐ Male ☐ Female / Date of Birth (Mo/Day/Yr)	(Mo/Day/Yr) ☐ Married
City State ZIP Code +4	County (Residence)	Medical/Dental Effective Date (Mo/Day/Yr)
Mailing Address (if different than above) City State ZIP Code +4		County (Residence)

Relationship	Last Name First Name Middle Initial	Social Security Number	Date of Birth (Mo/Day/Yr)
SPOUSE			
Permanent Residential or Mailing Address (if different from above)	City	State	ZIP Code +4

Medicare

Retiree

Retiree Name _____

Medicare Claim Number

Is entitled to Effective Date Effective Date

Hospital (Part A) _____ Medical (Part B) _____

Spouse

Spouse Name _____

Medicare Claim Number

Is entitled to Effective Date Effective Date

Hospital (Part A) _____ Medical (Part B) _____

PCP and Plan Choice

I wish to cancel my current medical coverage:
☐ Yes ☐ No

I wish to enroll in/change medical plans as indicated:
☐ Group Health Cooperative ☐ Kaiser Senior Advantage ☐ PacifiCare Secure Horizons

I wish to cancel my current dental coverage: ☐ Yes ☐ No

I wish to enroll in/change dental plans as indicated:
☐ DeltaCare–Dentist or clinic code _____
☐ Regence BlueShield Columbia Dental Plan–Clinic location _____
☐ Uniform Dental Plan

Retiree

Name of Contracting Primary Care Physician (PCP) (refer to Provider Directory) _____

Are you a current patient? ☐ Yes ☐ No

Spouse

Name of Contracting Primary Care Physician (refer to Provider Directory) _____

Are you a current patient? ☐ Yes ☐ No

Medical Information

1. **Do you currently have end-stage renal disease (kidney disease)?** Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No
   If yes, are you currently a member of PacifiCare of Oregon/ Washington? Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No
2. **Do you have any health insurance other than Medicare?**
   Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No
   If yes, through which company? _____
   What type of policy? _____
   Do you intend to discontinue this policy?
   Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

Note: Your answers to questions #3 and #4 below will **not** affect your eligibility to enroll in a Medicare+Choice plan.

3. **Do you live in an institution?**
   Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No
   If yes, name of institution _____
   Address _____
   Phone number _____
   Date of admission _____
4. **Are you currently receiving Medicaid?** Retiree: ☐ Yes ☐ No
   Spouse: ☐ Yes ☐ No If yes, Medicaid #: _____

Signature and Authorization

I authorize Department of Retirement Systems to deduct from my retirement allowance the amount required to pay for this coverage. ☐ Yes ☐ No

I certify that to the best of my knowledge and belief, my dependents and I are eligible for the coverage requested. I understand that if I enroll in dental coverage, I must maintain dental coverage for at least two years. This supersedes all forms I have previously submitted for Public Employees Benefits Board coverage. A premium deposit does not guarantee coverage and will be refunded if I am determined to be ineligible for coverage.

My signature below warrants that I have read and understand this Medicare+Choice Plan Election Form, including the Statement of Understanding on the back of this form, and that the information provided by me is accurate and complete. Please refer to the Medicare+Choice plan's Evidence of Coverage document for a written copy of the rules you must follow in order to receive coverage under this Medicare+Choice plan contract. A copy of your selected Medicare+Choice Evidence of Coverage document will be sent to you upon receipt of your enrollment by the plan.

You must sign the printed copy to autho _____ You must sign the printed copy to autl _____

Signature of Applicant (see Privacy Notice on back) Date — Signature of Spouse Date

Printed copy must be signed if an individual assiste _____ _____

Signature of individual who assisted the applicant and/or spouse in completing this form Date — Relationship to Applicant/Spouse

☐ If Durable Power of Attorney for Health Care (DPAHC) for applicant and/or spouse, indicate here and attach certificate or other written proof of legal guardianship.

HCA51-576 (10/02)

Return to: Washington State Health Care Authority; PO Box 42684; Olympia, WA 98504-2684

STATEMENT OF UNDERSTANDING

I understand that beginning on my effective date with the Medicare+Choice plan I have selected on the reverse of this form, all medical services, with the exception of emergency, or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization of my Medicare+Choice contracting primary care physician (PCP) will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or under unusual and extraordinary circumstances, provided when I am in the service area, but my contracting medical group is temporarily unavailable or inaccessible).

I understand that I can be a member of only one Medicare+Choice coordinated care plan at any time. By enrolling in the Medicare+Choice plan I have selected, I will automatically be disenrolled by the Health Care Financing Administration (HCFA) from any other Medicare+Choice coordinated care plan of which I may be a member.

By enrolling in the Medicare+Choice plan, I authorize the Health Care Financing Administration to provide information to the Medicare+Choice plan I select confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and to Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the Medicare+Choice plan's provider or any other holder of medical or other relevant information about me to release to HCFA or HCFA's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including–but not limited to–physicians, hospitals, insurance companies and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision of or coordination of benefits or the professional review activities.

I understand that it is my responsibility to inform the Medicare+Choice plan I have selected prior to either permanently moving out of the service area or leaving the service area for more than twelve (12) months, and that my absence means the plan must disenroll me and return me to the original Medicare coverage.

I understand that I may disenroll from this Medicare+Choice plan by sending a written request to the Medicare+Choice plan I have selected, the Social Security Office, or the Railroad Retirement Board. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare+Choice plan providers.

I understand that as a member of the Medicare+Choice plan, I have the right to appeal service and payment denials made by the plan.

I understand that my enrollment in the Medicare+Choice plan I have selected is effective with my date of retirement or January 1, if enrolling during the Public Employees Benefits Board (PEBB) annual open enrollment period. I understand that upon confirmation from HCFA, the Medicare+Choice plan will send me written notice of my effective date. As of my enrollment effective date, all of my routine health care must be provided for by plan-contracting medical providers.

Note: Until you have received this written notification, you should not drop any supplemental insurance you have in effect now.

This form represents your temporary Medicare+Choice plan identification card. Until you receive your Medicare+Choice identification card, please keep it with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare+Choice organization provides the member, prior to the effective date, evidence of health insurance coverage so that (s)he may begin using the plan services as of the effective date.

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.pebb.hca.wa.gov